STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 88171-001-SF**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 26th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 27, 2008, XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it for external review on March 5, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on March 13, 2007.

The Petitioner is enrolled for health coverage with BCBSM through the Michigan Public School Employees Retirement System (MPSRS), a self-funded group. The issue in this external

review can be decided by a contractual analysis. The contract involved here is the MPSERS/BCBSM *Your Benefit Guide* (the guide). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On November 26, 2007, the Petitioner requested that XXXXX pharmacy refill her prescription for the drug Norvasc. When she received the bill from XXXXX it was for $50.04 more than she thought it should be. When she inquired she was told that the $50.04 was the difference between the cost of the generic and the brand name drug. Since the prescription was written as DAW ("dispense as written"), XXXXX was required to provide the brand name drug.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on January 23, 2008, and issued a final adverse determination dated January 30, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the prescription drug provided the Petitioner on November 26, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner indicates that her doctor's partner wrote the prescription for Norvasc and faxed it to XXXX. She was unaware that the prescription was written with a "DAW" designation. She was also not aware that the prescribed drug, Norvasc, had recently become available in a generic form. Had she been informed of these facts she could have requested the generic and would not have been charged the $50.04 difference between the cost of the generic and brand name drug. Petitioner says that, since it was not her fault that the brand name drug was dispensed,

BCBSM should refund her the $50.04.

BCBSM's Argument

BCBSM says the guide sets out its policy on generic drugs on page 51. It states:

> If there is a generic equivalent to a brand-name drug, the pharmacist will dispense the generic drug when appropriate. If you or your physician request the brand name drug when a therapeutically-equivalent generic is available, you will pay the difference between Blue Cross Blue Shield's approved amount for the brand-name drug and the approved amount for the generic, plus your copay. The copay will be based on the approved amount of the generic drug instead of the brand-name drug.

There is no dispute that the Petitioner's prescription in this case was written with the letters "DAW" (dispense as written). The DAW requires the pharmacist to provide the brand name drug even when a generic is available. Therefore, the Petitioner is responsible for the difference between the approved amount of the brand-name drug and the generic drug. In this case that amount is $50.04.

The Petitioner argues she should not be responsible for the $50.04 because she was unaware that a generic was available and it was her primary care physician's partner that wrote the DAW on the prescription. Because she was not informed that a generic was available she lost the right to choose this option.

BCBSM indicates that it is required to follow the provisions of the certificate. Since a brand-name was dispensed when a generic was available the Petitioner is responsible for the $50.04 difference between the cost of the brand-name and the generic.

Commissioner's Review

The guide describes how benefits are paid. It explains that when a brand-name drug is dispensed when a generic is available the patient is responsible for the difference in the approved amount of the two drugs. When a physician writes the letters "DAW" on a prescription for a brand-name drug, the pharmacist is not permitted to substitute the generic equivalent. Therefore, the pharmacist in this case was obligated to provide the brand-name drug. Had DAW not been written

on the prescription the pharmacist would have dispensed the generic and the Petitioner would not have been responsible for the $50.04 difference in price.

The Petitioner argues that she was unaware that a generic was available for her prescription drug and did not know that the prescription was written with the “dispense as written” code. This does not change the fact that a brand-name was provided by the pharmacy as directed by the physician. When this happens the Petitioner is responsible for the difference in the approved amount for the brand-name and generic drug.

The Commissioner finds that the Petitioner is required to pay the $50.04 difference between the approved amount for her brand-name drug and it generic equivalent that was prescribed on November 26, 2007.

V
ORDER

BCBSM’s final adverse determination of January 30, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner’s November 26, 2007 prescription.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.